

## Notice of Independent Review Decision

### **IRO REVIEWER REPORT**

DATE OF REVIEW: 07/06/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Revision lumbar spine at L2-3-4-5-S1; hardware removal, anterior instrumentation, posterior instrumentation at L5-S1; repair as indicated at L2-3 w/ 2day LOS-inpt 63042, 63044,6990-99, 22612, 22851, 20938, 22840, 22558, 20975, 63685-99, 22525, 22852

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)  
 Overturned (Disagree)  
 Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the revision lumbar spine at L2-3-4-5-S1; hardware removal, anterior instrumentation, posterior instrumentation at L5-S1; repair as indicated at L2-3 w/ 2day LOS-inpt 63042, 63044,6990-99, 22612, 22851, 20938, 22840, 22558, 20975, 63685-99, 22525, 22852 are medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 06/22/10
- Preauthorization determination letter from xxxxx – 05/28/10, 06/15/10
- Email denial letter – 05/28/10
- Report of lumbar myelogram – 05/11/10
- Report of post-myelogram CT of the lumbar spine 05/11/10
- Chiropractic Review by Dr.– 01/09/09
- Peer Review by Dr.– 02/24/10
- Letter from Dr.– 01/22/10
- Report of required medical examination by Dr.– 11/18/09
- Partial copy of an examination performed by Dr.– no date
- Report of medical record review by Dr.– 01/08/09
- Office visit notes by Dr.– 03/30/10 to 05/18/10
- SOAP notes by Dr.– 03/12/10
- Chart notes from xxxxx – 05/08/08 to 01/21/10

- Report of electrodiagnostic studies – 03/12/09

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient with a history of previous back problems and previous back surgery sustained a work related injury on xx/xx/xx when she experienced low back pain while unloading parts on a rolling rack. She has been treated with physical therapy, medications and surgery. The patient complains of increased back pain as well as both urinary and bowel incontinence. The treating orthopedic surgeon is recommending surgical intervention in the form of a revision lumbar spine at L2-3-4-5-S1; hardware removal, anterior instrumentation, posterior instrumentation at L5-S1; repair as indicated at L2-3.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

This patient has failed previous back surgery leading to defects and deficiencies at multiple levels of the lumbar spine. In order to correct this patient's problems, it is necessary to start over and proceed with a 360 degree laminectomy and fusion, posterior and anterior, interbody and posterolateral from L3 to S1 plus adequate compressing at all levels. Based on the documentation provided, the proposed procedures are the most appropriate treatment for this patient's condition.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)